Portsmouth Safeguarding Adults Board

Annual Report

PSAB

2017 - 2018

Statement from the Independent Chair

I am pleased to be able to introduce the Portsmouth Safeguarding Adults Board's Annual Report for 2017/18. As a Board, our aim is to provide strategic leadership to ensure adults with care and support needs, who are at risk of abuse or neglect are effectively safeguarded. Prevention and early intervention is critical to this vision as is the need to identify and apply learning when people experience poor outcomes. We place equal focus on developing a safeguarding culture that focuses on the personalised outcomes desired by those people who may have been abused and who wish to access support.

We are being encouraged from a national perspective to work with the following key themes in relation to Adult Safeguarding:

- Prevention
- Making Safeguarding Personal
- Quality

These themes are reflected within our Business plan for the coming year. In particular I wanted to highlight that there are now resources available from the Association of Directors of Adult Social Services and the Local Government Association to describe what 'good' might look like in Making Safeguarding Personal and promotes ownership of this agenda within and across all organisations.

The recent publication of the Independent Inquiry into deaths at Gosport War Memorial Hospital[1] (and also other similar reports affecting the health and social care landscape across Hampshire such as the Mazars review of deaths at Southern Health NHS Foundation Trust)[2] means that going forward Portsmouth Safeguarding Adults Board will be placing a specific focus on gaining assurance from partner agencies of their processes to follow up unexpected deaths.

Given the context of increased pressures within all sectors, I am keen that the Board continues to identify opportunities for increased joint working and coordination across the wider strategic partnership.

Significant progress has been achieved in undertaking joint work with our neighbouring local safeguarding adults boards as well as the Portsmouth Safeguarding Children Board. This approach has led to the introduction of new pan-Hampshire ('4LSAB') work groups addressing areas of common interest. We continue to maximise opportunities for joint working with the Portsmouth Safeguarding Children Board leading to the development of a Whole Family Protocol.

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[1] Gosport Independent Panel, *The Panel Report,* https://www.gosportpanel.independent.gov.uk/panel-report/

[2] Mazars LLP, *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015*, https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

What is Safeguarding?

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action." (Care Act 2014)

Who are we?

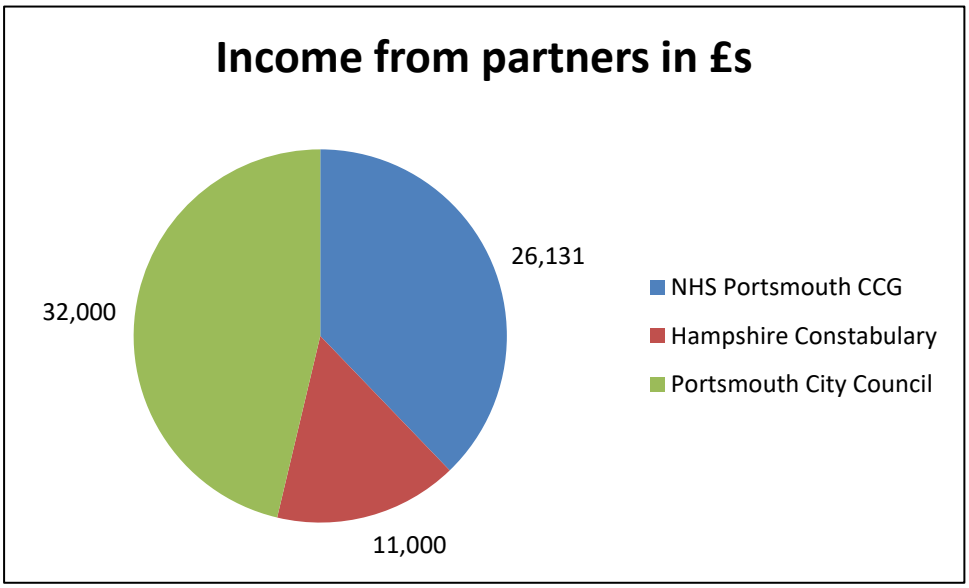
The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

- Adult social care
- Health
- Emergency services
- Probation services
- Housing
- Community organisations

The board has an independent chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- offering constructive challenge
- holding member agencies to account
- acting as a spokesperson for the PSAB.

The Board is funded through contributions from its statutory partners (Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group and Hampshire Constabulary). The agreed contributions are:



Our Vision

"Portsmouth is a city where adults at risk of harm are safe and empowered to make their own decisions and where safeguarding is everyone's business."

Safeguarding Duty

Under Section 42 of the Care Act, a local authority has a duty to make enquiries or cause others to make enquiries in cases where it has reasonable cause to suspect

- that an adult has needs for care and support (whether or not the local is meeting any of those needs) and
- is experiencing, or at risk of, abuse or neglect and
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or experience of, abuse or neglect.

Portsmouth has an Adult Multi-Agency Safeguarding Hub (MASH). Hampshire Constabulary and Portsmouth City Council have created the MASH with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards and children's safeguarding. The MASH manages a high volume of referrals.

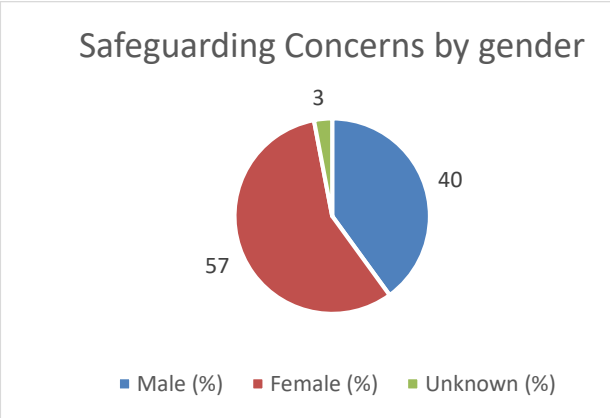
Safeguarding Activity

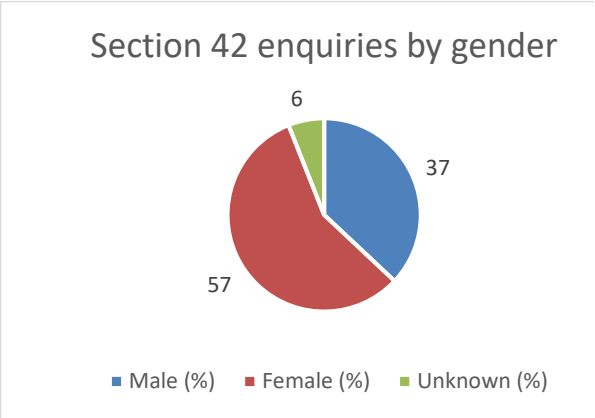
A *concern* is a 'worry' raised regarding a person's safety. There were 1779 concerns raised in 2017-18.

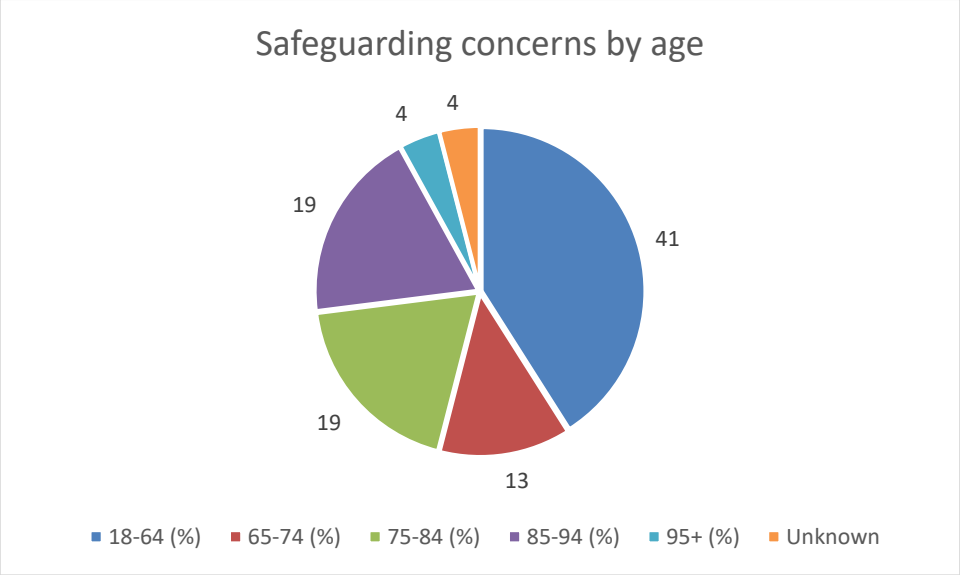
An *enquiry* is what needs to be looked at to confirm a person is safe. 195 were deemed to require further input and were taken forward as enquiries under Section 42 of the Care Act.

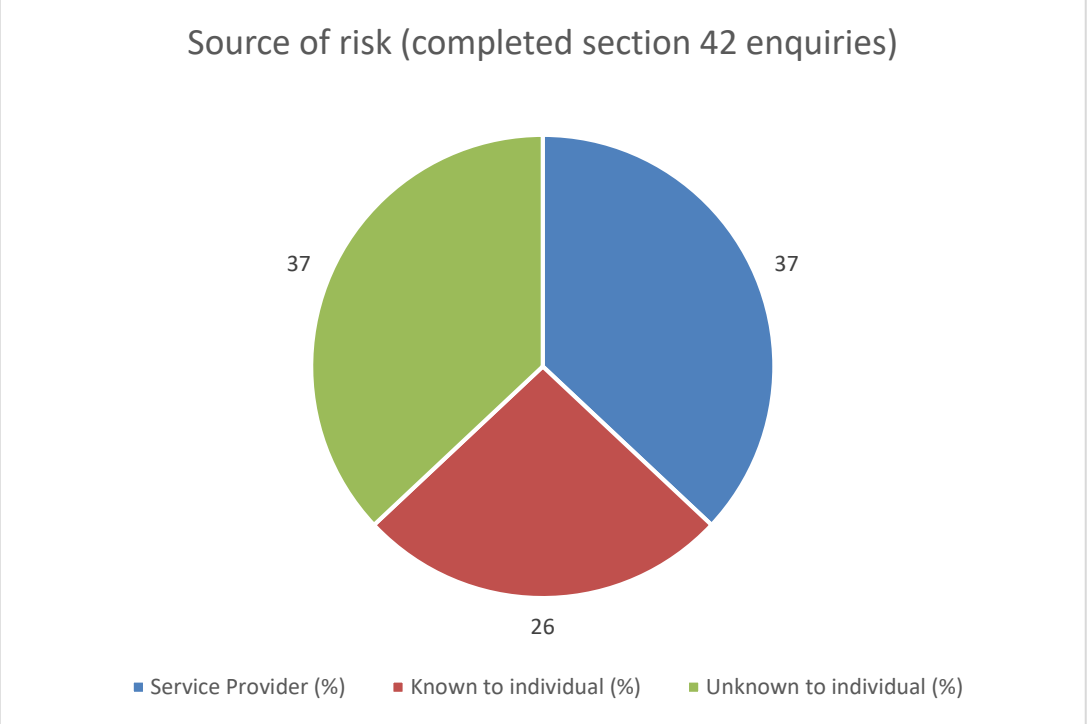
Data collected by the MASH gives further information about who has experienced abuse or neglect in Portsmouth, where abuse has taken place, and the types of risk they have experienced.

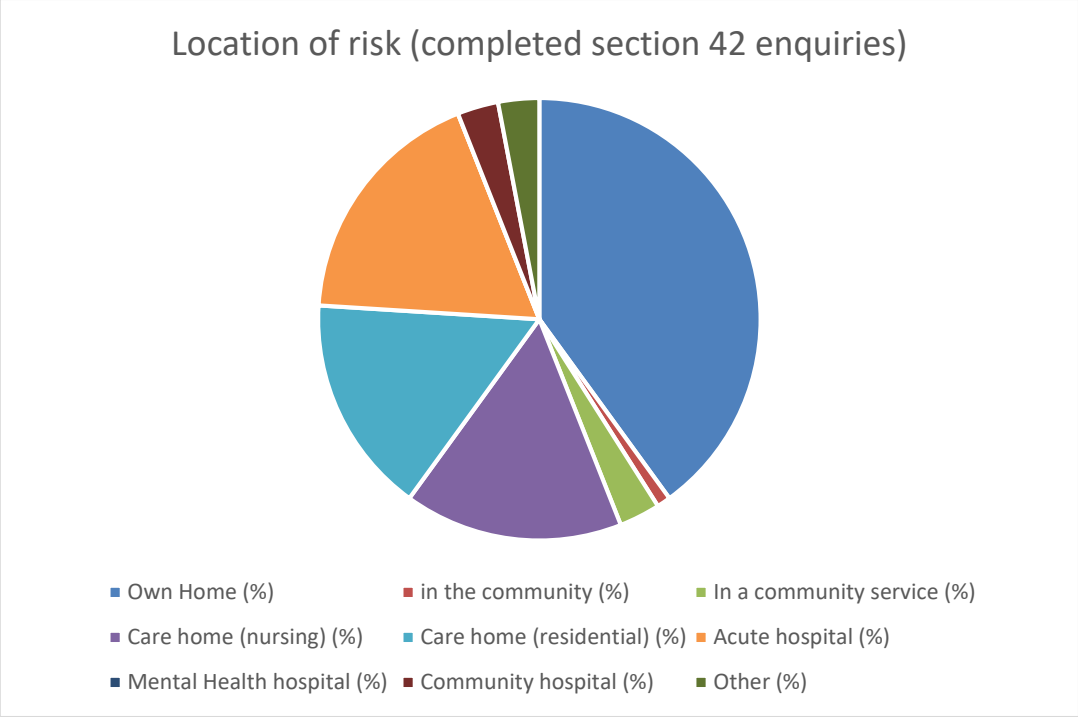
For the coming year, work will be undertaken with the other Local Safeguarding Adults Boards in Hampshire to establish a common dataset which will give the Board a greater understanding of safeguarding data drawn from all partners, and enable comparisons across the area.

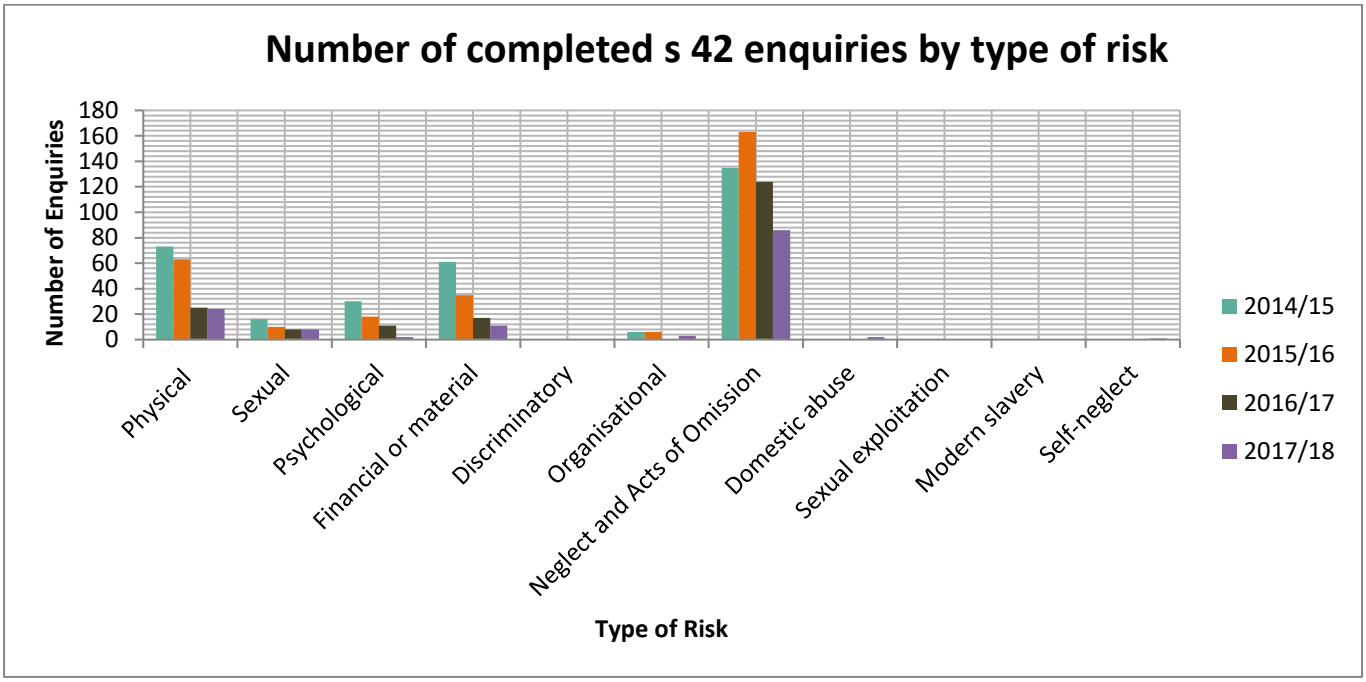





Safeguarding concerns by age
4
4
19
41
19
13
18-64 (%)
65-74 (%)
75-84 (%)
85-94 (%)
95+ (%)
Unknown

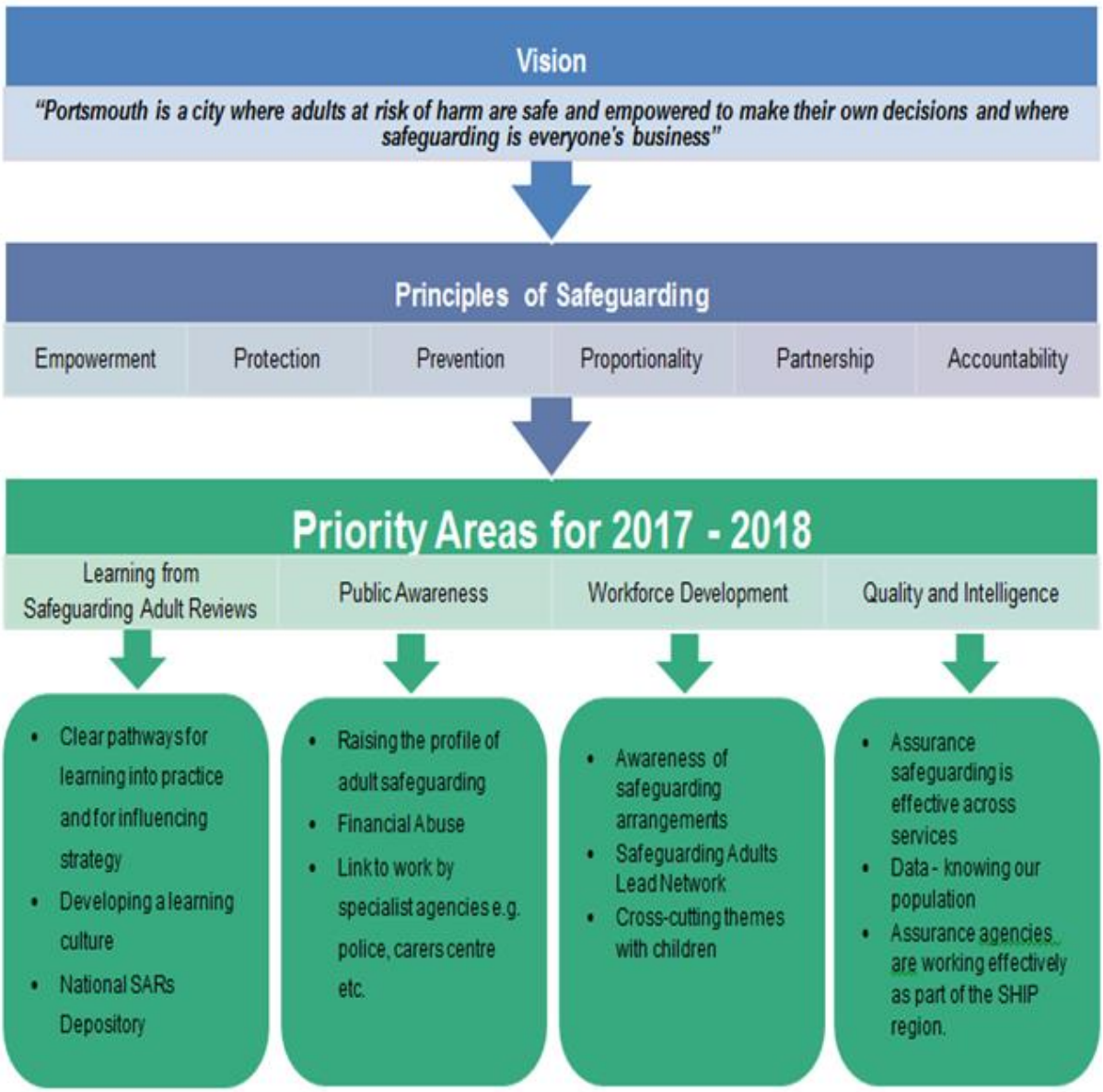

Source of risk (completed section 42 enquiries)
37
37
26
Service Provider (%)
Known to individual (%)
Unknown to individual (%)


Location of risk (completed section 42 enquiries)
Own Home (%)
in the community (%)
In a community service (%)
Care home (nursing) (%)
Care home (residential) (%)
Acute hospital (%)
Mental Health hospital (%)
Community hospital (%)
Other (%)


Number of completed s 42 enquiries by type of risk
Number of Enquiries
180
160
140
120
100
80
60
40
20
0
Physical
Sexual
Psychological
Financial or material
Discriminatory
Organisational
Neglect and Acts of Omission
Domestic abuse
Sexual exploitation
Modern slavery
Self-neglect
Type of Risk
2014/15
2015/16
2016/17
2017/18

Progress on 2017-18 strategic plan

Our priorities for 2017-18 are summarised below:



Learning from Safeguarding Adult Reviews

The Care Act 2014 states that a Safeguarding Adults Review (SAR) must take place when:

"There is reasonable cause for concern about how the Safeguarding Adult Board, members of it or others worked together to safeguard the adult, and death or serious harm arose from actual or suspected abuse".

The PSAB has a SAR sub-group which is chaired by the Deputy Director for Quality and Safeguarding from NHS Portsmouth Clinical Commissioning Group. The group is a multi-agency group with members who have a specialist role or experience in safeguarding adults. The group met monthly during 2017-18. In March 2017, the

SAR sub-group started a pilot joining up with the Portsmouth Safeguarding Children Board's (PSCB) Case Review Committee (CRC) to work together on cases which might involve both children and adult services. The pilot was reviewed during 2017-18 and it was concluded that there were many positive outcomes, including:

- Good relationships being built between adults and children's services
- That there are benefits on issues in common being looked at jointly by both groups
- There have been some good outcomes from some of the reflective practice events.

These joint meetings have now become a permanent way of working.

Summary of SAR activity during 2017-18

Four new SAR referrals were received in 2017-18. One of these referrals was found to meet the criteria for a SAR. The PSAB has therefore commissioned a SAR. A panel has been set up and an independent author has been engaged to write a report on the case. This work is due to be undertaken in 2018-19. For a second case, scoping has been initiated to identify whether or not the criteria for a SAR have been met.

In two further cases, after investigation, it was decided that they did not meet the criteria for a SAR. Through the NHS serious incident review process, learning was identified for prison health services and recommendations were communicated to the relevant service.

During 2017-18 the SAR sub-group took forward work on referrals from the previous year to ensure that relevant learning was identified and embedded within organisations. For example, a joint children and adult's multi-agency reflective practice workshop carried out as a result of a referral to PSCB CRC. The referral was made to the CRC in November 2016, regarding a child, but the case also involved an adult at risk. The criteria for a Serious Case Review was not met but the CRC and the SAR sub-group decided to proceed with a joint multi-agency reflective practice meeting. This would consider how agencies had worked together and what lessons could be learned to improve the outcomes in future situations.

Findings and Learning Points

- Tendency of services to focus on isolated incidents. Lack of seeing the bigger picture of the situation.
    - The sum impact of events needs to be considered
    - Individual agencies to be assured that they understand how to identify and respond to the cumulative effect of individual incidents and escalate / refer accordingly.

- Both individuals seen by multiple agencies on multiple occasions i.e. lots of input but not coordinated as no individual / agency seemed to be taking the lead.

    - To allow for more effective multi-agency working there needs to be an understanding of different agencies and individual roles, and in particular where responsibility of each starts and finishes

- The high intensity user group at the hospital agreed an approach to manage the mother's attendance at the Emergency Department, but didn't consider the impact this may have had on the child and other family members.
    - Agencies to consider risk assessing the impact of withdrawing services to the individual on the wider family.

A member of the Portsmouth SAR sub-group was on the panel for a SAR carried out by Hampshire SAB (Mr C) and it is planned that in 2018-19 the recommendations from that SAR will be reviewed by the sub-group so that any learning relevant to Portsmouth organisations can be acted upon.

On a national level, PSAB will engage with the new national library of SARs which is being established by the Social Care Institute for Excellence and the Learning Disabilities Mortality review programme to ensure that learning from other areas is considered within Portsmouth.

Public Awareness

During the year, work on re-branding PSAB has been completed, with a new logo launched. The website has been updated to reflect the new branding. A Twitter account has also been set up for the Board to enable communication of key messages about adult safeguarding through social media. This will assist with communication with the public, service users, stakeholders and professionals. The Board has also been working on developing some easy-read information about safeguarding. A pan-Hampshire approach has been taken to publicity materials for the Board, with posters and leaflets being shared with the other Local Safeguarding Adults Boards.

Workforce Development

Work has been undertaken to establish workforce development on a pan-Hampshire basis (see below). A 4LSAB workforce sub-group has been established, with the remit to review and map workforce development activity across the area and to develop a regional training offer.

On the national level, the Independent Chair has been involved with the development of a workforce framework focusing on the role of the Safeguarding Adults Board Chair.

Quality and Intelligence

A key part of work in this area has been the establishment of a Safeguarding Improvement Board to support Portsmouth Hospitals NHS Trust to address areas of concerns identified by the Care Quality Commission (CQC) (see below for further detail).

PSAB partners have also been engaged in work to address the number of providers rated as 'inadequate' or 'requires improvement' by CQC. Plans have been put in place by Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group to establish a joint quality improvement team to work with residential and domiciliary care providers to improve care quality within Portsmouth.

On a pan-Hampshire basis, a Quality Assurance sub-group has been established and a workshop was held, hosted by Hampshire Constabulary, to plan the work programme for this group.

Nationally, work is underway to understand (via a SAB Chairs' audit) how Safeguarding Adults Boards are using NHS Digital data and how this data can drive more effective intelligence and decision-making.

Other activity

The Board has considered other key areas of concern which arose during the year. For example, they received presentations on Prevent and on Suicide Prevention. Following the tragic events at Grenfell Tower, the Board sought assurance from Housing and Hampshire Fire and Rescue on the response within Portsmouth.

Case Study: Safeguarding Improvement Board

During 2017-18 two inspection reports from the Care Quality Commission (CQC) were published regarding the quality of health provision in Portsmouth

- CQC Portsmouth Hospitals NHS Trust, Queen Alexandra Hospital Quality Report (publication date 24th August 2017).
- CQC Review of health services for Children Looked After and Safeguarding in Portsmouth (publication date 19th September 2017).

These reports both identified areas of good practice as well as some areas concern relating to safeguarding of both adults and children in Portsmouth's health services.

To ensure that both the PSAB and the Portsmouth Safeguarding Children Board had sufficient oversight of the improvement activity in partner agencies, whilst not overly burdening them with duplication of reporting, a Joint Safeguarding Improvement Board was convened. This Board was constituted as a sub-group of both PSAB and PSCB on a task-and-finish basis and had agreed terms of reference. As two-thirds of the patients attending Portsmouth Hospitals Trust live in Hampshire, the Safeguarding Improvement Board has also sought to work in partnership with the Hampshire Safeguarding Adults Board and the Hampshire Safeguarding Children Board.

This Board is jointly chaired by the Independent Chairs of the PSAB and PSCB and the membership is made up of:

- Chief of Health & Care Portsmouth, NHS Portsmouth CCG/Portsmouth City Council
- Deputy Director of Quality and Safeguarding, NHS Portsmouth CCG
- Head of Safeguarding, Portsmouth Hospitals NHS Trust

- Associate Director of Quality and Governance, Portsmouth Hospitals NHS Trust
- Public Health Consultant, Public Health
- Director of Children's Services, Portsmouth City Council
- Head of Health & Wellbeing Partnerships, Healthwatch Portsmouth
- Associate Director Quality & Nursing, South Eastern Hampshire/Fareham and Gosport Hampshire CCG Partnership
- District Manager for Hampshire Children's Services, Hampshire County Council
- Chief Superintendent, Head of Prevention and Neighbourhood Command Hampshire Constabulary
- Board Manager, Portsmouth Safeguarding Adults Board
- Safeguarding Partnerships Manager, Portsmouth Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Adults Board

The objectives of the Safeguarding Improvement Board are:

a. To ensure appropriate actions have been identified and undertaken to address the areas of concern
b. To provide a direct line of reporting and accountability for the actions / work streams being undertaken by providers
c. To provide an accessible escalation route to address any areas that may prevent or hinder the necessary actions being taken
d. To provide strategic support to providers as required.

The PSAB commissioned independent consultants CPEA to produce a report and recommendations to initiate the work.

Portsmouth Hospitals Trust, Solent NHS Trust, Portsmouth Clinical Commissioning Group, Public Health and the Society of St James all developed detailed action plans in response to the recommendations in these reports.

This work is ongoing and aims to be completed by September 2018, at which point any actions still outstanding will be reviewed by the PSAB and PSCB respectively.

Board structure and pan-Hampshire ('4LSAB') working

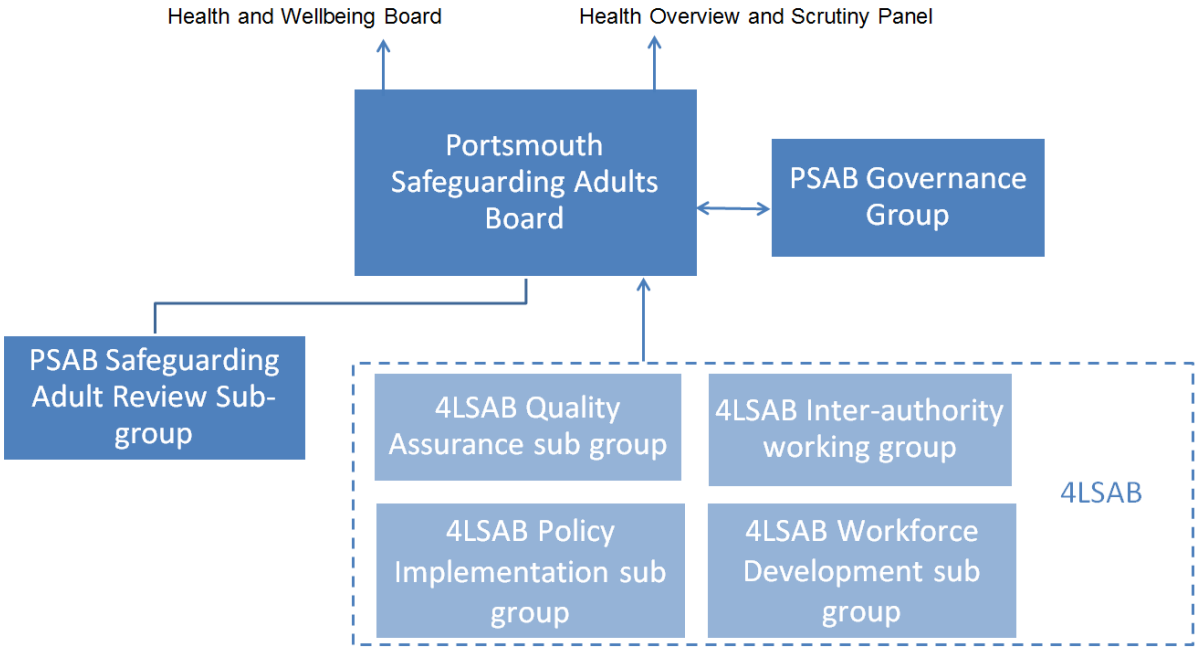
Over the past year, we have made significant progress to ensure we are working in a joined up and coordinated way with our Safeguarding Adult Board colleagues in the neighbouring local authority areas (Hampshire, Southampton and the Isle of Wight). This approach recognises the fact that the membership and priorities of our respective Safeguarding Adults Boards are often overlapping.

We have therefore, established joined working groups for Policy Implementation, Workforce Development and Quality Assurance and have agreed a shared vision and common objectives for these areas. We recognise however, the importance of flexibility to enable each individual Board to address specific priorities and objectives relevant to their Board and/or locality.

This joined approach has enabled us not only to reduce duplication but has also led to greater effectiveness and impact in a number of important areas including:

- Availability of consistent multi-agency policy and guidance.
- Sharing of expertise and best practice.
- Improved delivery of training and development.
- Wider application of learning from serious cases.
- Better use of time and resources for the Boards and partners.

Our new Board structure is set out in the diagram below:



Our Priorities for 2018-19 and beyond

During 2018 the Board has reviewed its approach to strategic planning, and has decided that a longer term approach would be beneficial. Strategic planning is now more firmly underpinned by a multi-agency assessment of key risks to keeping people safe across the City. The following priorities have been adopted for a three year planning cycle 2018-19 to 2020-21. Progress against the priorities will be reviewed on an annual basis.

1. Improve practice on MCA and DoLs
2. Reduce the number of care providers rated inadequate or requires improvement by CQC
3. Pan-Hampshire working a. Embed 4LSAB working b. Reduce Fire Deaths across 4LSAB area c. Ensure 4LSAB policies are translated into practice (Hoarding, Escalation, Family Approach, Thresholds) d. Develop vulnerability toolkit

e. Learning from deaths work
4. Improve the quality of transition
5. Ensure PSAB decision making is underpinned by robust data
6. Improve safeguarding adults practice within Portsmouth

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